Women/Maternal Health

State Action Plan Table (New York) - Women/Maternal Health - Entry 1
Priority Need
Address equity, bias, quality of care, and barriers to access in health care services for women and families, especially for communities of color and low-income communities
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)
Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)
Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)
Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)
Strategies
Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.
Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.
Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care.
Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.

ESMs	Status
ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs

- NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NOM 3 - Maternal mortality rate per 100,000 live births
- NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
- NOM 5 - Percent of preterm births (<37 weeks)
- NOM 6 - Percent of early term births (37, 38 weeks)
- NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.2 - Neonatal mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.4 - Preterm-related mortality rate per 100,000 live births
- NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
- NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
- NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
- NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New York) - Women/Maternal Health - Entry 2

Priority Need

Acknowledge and address the fundamental challenges faces by families in poverty and near-poverty, including the “working poor” as a result of systemic barriers, including racism.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Objective WMH-1: Increase the percent of women, ages 18 through 44, with a preventive medical visit in the past year by 5%, from 79.6% in 2018 to 84.6% in 2022. (BRFSS)

Objective WMH-2: Reduce the maternal mortality rate by 10%, from 17.8 deaths per 100,000 live births in 2014-2018 to 16 deaths per 100,000 live births in 2018-2022. (NVSS)

Objective WMH-3: Reduce the rate of severe maternal morbidity per 10,000 delivery hospitalizations by 5%, from 80 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2017 to 76 delivery hospitalizations with an indication of severe morbidity per 10,000 delivery hospitalizations in 2021. (HCUP-SID)

Objective WMH-4: Reduce the percent of women who have depressive symptoms after birth by 5%, from 13% in 2017 to 12.4% in 2021. (PRAMS)

Strategies

Strategy WMH-1: Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care.

Strategy WMH-2: Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous.

Strategy WMH-3: Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women’s health care.

Strategy WMH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women’s health and use of health care across the life course.

ESMs	Status
ESM 1.1 - Percent of Maternal and Infant Community Health Collaboratives (MICHC) program participants engaged prenatally who have created a birth plan during a visit with a Community Health Worker (CHW)	Active
ESM 1.2 - Percent of Family Planning Program (FPP) clients with a documented comprehensive medical exam in the past year	Active

NOMs

- NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
- NOM 3 - Maternal mortality rate per 100,000 live births
- NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
- NOM 5 - Percent of preterm births (<37 weeks)
- NOM 6 - Percent of early term births (37, 38 weeks)
- NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
- NOM 9.1 - Infant mortality rate per 1,000 live births
- NOM 9.2 - Neonatal mortality rate per 1,000 live births
- NOM 9.3 - Post neonatal mortality rate per 1,000 live births
- NOM 9.4 - Preterm-related mortality rate per 100,000 live births
- NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
- NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
- NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
- NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Perinatal/Infant Health

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 1	
Priority Need	
Address transportation barriers for individuals and families.	
NPM	
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Objectives	
Objective PIH-1: Increase or maintain the percent of very low birth weight infants born in a hospital with a Level III+ NICU by 2.4%, from the 2017 level of 91.2% to 93.4% by 2021. (NYS Vital Statistics Birth Data)	
Objective PIH-2: Decrease the infant mortality rate by 2.6%, from 4.6 deaths per 1,000 live births in 2017 to 4.49 deaths per 1,000 live births in 2021 (NVSS)	
Strategies	
Strategy PIH-1: Integrate specific activities across all relevant Title V programs to promote access to early prenatal care, access to birthing facilities appropriate to one's needs, postpartum care, and infant care.	
Strategy PIH-2: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers.	
Strategy PIH-3: Apply public health surveillance and data analysis findings to improve services and systems related to perinatal and infant health care.	
Strategy PIH-4: Address social determinants identified by community members that impact infant health and use of perinatal and infant health care and support services.	
ESMs	**Status**
ESM 3.1 - Percent of birthing hospitals with final level of perinatal care designation, in accordance with updated regulations and standards	Active
NOMs	
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.2 - Neonatal mortality rate per 1,000 live births	
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	

State Action Plan Table (New York) - Perinatal/Infant Health - Entry 2

Priority Need

Increase awareness of resources and services in the community among families and the providers who serve them.

SPM

SPM 1 - Percent of samples received by the State Newborn Screening lab within 48 hours of collection

Objectives

Objective PIH-3: Improve the timeliness of Newborn Blood Spot samples received at the NYSDOH Wadsworth Laboratory from 74.34% to greater than 85% of samples received within 48 hours of collection by September 2023. (Newborn Blood Spot data)

Strategies

Strategy PIH-5: Maintain and strengthen a robust statewide population-based Newborn Screening Program.

Child Health

State Action Plan Table (New York) - Child Health - Entry 1	
Priority Need	
Increase access to affordable fresh and healthy foods in communities.	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).	
Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).	
Strategies	
Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.	
Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.	
Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.	
Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being.	
ESMs	**Status**
ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

State Action Plan Table (New York) - Child Health - Entry 2

Priority Need

Address community and environmental safety for children, youth, and families.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

Objective CH-1: Increase the percent of NYS children age 6-11 who are physically active at least 60 minutes per day by 3.7%, from 27% in 2017-2018 to 28% in 2021-2022 (NSCH).

Objective CH-2: Decrease the percent of NYS children age 10-17 who are obese (BMI at or above the 95th percentile) by 2.8%, and from 14.4% of children age 10-17 in 2017-2018 to 14% in 2021-2022 (NSCH).

Strategies

Strategy CH-1: Promote evidence-based and family-centered health care for children to promote healthy behaviors and to prevent, identify, and manage chronic health issues so that children can be healthy and active.

Strategy CH-2: Promote home, school, and community environments that support developmentally appropriate active play, recreation, and active transportation for children of all ages and abilities.

Strategy CH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.

Strategy CH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact children’s health and well-being.

ESMs	Status
ESM 8.1.1 - Percent of children and youth enrolled in School Based Health Centers (SBHCs) who have documentation of anticipatory guidance that includes physical activity and nutrition during a visit to a SBHC within the past year.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health

State Action Plan Table (New York) - Adolescent Health - Entry 1
Priority Need
Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course
NPM
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Objectives
Objective AH-1: Increase the percent of adolescents, ages 12-17, with a preventive medical visit in the past year by 5%, from 81.3% in 2016-2017 to 85.4% in 2021-2022. (NSCH)
Objective AH-2: Increase the percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling by 5%, from 53.5% in 2017-2018 to 56.2% in 2021-2022. (NSCH)
Objective AH-3: Increase the percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine by 8%, from 67.3% in 2018 to 72.7% in 2022. (NIS)
Objective AH-4: Increase the percent of NYS adolescents without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 16.4% in 2017-2018 to 17.2% in 2021-2022. (NSCH)
Strategies
Strategy AH-1: Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health.
Strategy AH-2: Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood.
Strategy AH-3: Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care.
Strategy AH-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.

ESMs	Status
ESM 10.1 - Percent of youth-serving programs that provide training on adult preparation subjects, such as accessing health insurance, maintaining their routine preventive medical visits, healthy relationships, effective communication, financial literacy, etc.	Active
ESM 10.2 - Percent of youth-serving programs that engage youth, particularly youth representative of populations impacted by health disparities, in program planning and implementation	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Children with Special Health Care Needs

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 1
Priority Need
Enhance supports for parents and families, especially those with children with special health care needs, and inclusive of all family members and caregivers
NPM
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Objectives
Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)
Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)
Strategies
Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.
Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.
Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.
Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs.

ESMs	Status
ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 2

Priority Need

Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

Objective CYSCHN-1: Increase the percent of NYS adolescents with special health care needs, ages 12-17, who received services necessary to make transitions to adult health care by 5%, from 17.8% in 2017-2018 to 18.7% in 2021-2022 (NSCH)

Objective CYSCHN-2: Increase the percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system by 5%, from 15.2% in 2017-2018 to 16% in 2021-2022 (NSCH)

Strategies

Strategy CYSHCN-1: Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN.

Strategy CYSHCN-2: Enhance care coordination, including transition support services, for children and youth with special health care needs.

Strategy CYSHCN-3: Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs.

Strategy CYSHCN-4: Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs.

ESMs	Status
ESM 12.1 - Percent of individuals ages 14-21 with sickle cell disease who had transition readiness assessments completed, among those who were served through the Sickle Cell Disease Care Transition program and kept a routine medical appointment.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New York) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase the availability and quality of affordable housing.

SPM

SPM 2 - Incidence of confirmed high blood lead levels (5 micrograms per deciliter or greater) per 1,000 tested children aged less than 72 months

Objectives

Objective CYSHCN-3: Reduce the incidence of confirmed high blood lead levels at 5 micrograms per deciliter or greater per 1,000 tested children aged less than 72 months, with baseline incidence and benchmarks established in 2020-21 program year. The current incidence of confirmed blood lead levels at 10 micrograms per deciliter or greater is 3.7 per 1,000 children tested in 2016. (NYS Child Health Lead Poisoning Prevention Program Data)

Strategies

Strategy CSHCN-5: Support comprehensive public health efforts to prevent, identify, and manage childhood lead poisoning.